# PEDIATRIC HEALTH HISTORY

Child's Name: _____ Date: _____

Birthdate: _____ Child's Age: _____ Sex: ❍ Male ❍ Female

Parent or Guardian's Name: _____

Address: _____ City / Town: _____

Postal Code: _____ Home Phone: _____ Other Number: _____

Family Doctor's Name: _____ Clinic: _____

Clinic Address: _____

Who may we thank for referring you? _____

Has your child ever recieved chiropractic care: ❍ Yes ❍ No Date of last visit: _____

If yes, who was your child's previous Doctor of Chiropractic: _____

The reason for last visit: _____

**PRESENT HEALTH CONCERNS** (Please tell us about your reason for coming to our clinic)

Primary Concern: _____

_____

_____

Secondary Concern: _____

_____

_____

When did the problem begin? _____

Is this problem: ❍ frequent ❍ constant ❍ intermittent ❍ improving ❍ worsening

Does this problem radiate? ❍ Yes ❍ No If yes, where? _____

What makes this worse? _____

What makes this better? _____

Is the problem worse during certain times of the day? ❍ Yes ❍ No

If yes, when? _____

Does this interfere with sleep? ❍ Yes ❍ No Does this interfere with appetite / eating? ❍ Yes ❍ No

Does this interfere with daily routine? ❍ Yes ❍ No

Has another health care professional been seen for this condition? ❍ Yes ❍ No

Was there an treatment? ❍ Yes ❍ No Result of this treatment? _____

_____

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Recent tests (list date): ❍ Blood work _____ ❍ Urine _____ ❍ X-Rays _____

❍ Other _____

Does your child take any medications? What are the dosages? For what conditions? _____

_____

**Please indicate if any of the following are currently being experienced or have beem experienced in the last year:**

❍headaches ❍dizziness ❍irritability ❍fatigue ❍depression ❍fainting ❍dental issues
❍poor coordination ❍loss of memory ❍light sensitivity ❍loss of balance ❍vision changes
❍loss of smell ❍loss of taste ❍difficulty breathing ❍shortness of breath ❍allergies ❍bronchitis
❍pneumonia ❍fevers ❍ears buzzing ❍ear pain/infections ❍asthma ❍sinus congestion
❍sore throats ❍frequent colds ❍reduced mobility ❍cold sweats ❍constipation ❍diarrhea
❍bloating/gas ❍urinary problems ❍weight loss ❍weight gain ❍food allergies/sensitivities
❍heartburn ❍dental problems ❍muscle cramps ❍upper back pain ❍neck pain ❍low back pain
❍radiating pain ❍sleeping problems ❍numbness in leg(s) ❍body stiffness ❍body awkwardness
❍delayed crawling ❍delayed standing ❍delayed walking ❍delayed speech ❍poor visual tracking

Other_____

## Birth History

Was the birth: ❍ cesearian section ❍ vaginal birth

Was the child born: ❍ cephalic (head first) ❍ breech

Were there any complications? ❍ Yes ❍ No

Any illnesses during the pregnancy? ❍ Yes ❍ No

If yes, What medical attention was administerd? _____

_____

Any accidents or injuries during the pregnancy? ❍ Yes ❍ No

If yes, What happened? _____

_____

Any supplements taken during pregnancy? ❍ Yes ❍ No

If yes, What? For how long? Dosage? _____

_____

Any drugs taken during pregnancy? ❍ Yes ❍ No

If yes, What? For how long? Dosage? _____

_____

Did mother smoke during pregnancy? ❍ Yes ❍ No

If yes, How much? _____

_____

Did mother drink during pregnancy? ❍ Yes ❍ No

If yes, How much? _____

_____

Was your child's birth? ❍ at home ❍ in a birthing centre ❍ hospital ❍ other

Was the labor: ❍ spontaneous ❍ induced

Were medications or epidurals given to the mother during birth?: ❍ Yes ❍ No

Was there assistance of:

Vacuum ❍ Yes ❍ No

Forceps ❍ Yes ❍ No

Midwife ❍ Yes ❍ No

Duration of birth: _____ hours

What was the child's gestational age at birth? _____weeks

Birth weight: _____lbs _____oz
Birth Length: _____ inches

APGAR score:

At Birth: _____/10

After 5 minutes: _____/10

Did the child experience any of the following during or after their birth:

❍ bruising ❍ stuck in birth canal ❍ respiratory depression ❍ odd shaped head
❍ fast or excessively long birth ❍ cord around neck ❍ jaundice

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At what age did the child:

Respond to sound: _____ Roll over: _____

Hold up head: _____ Sit alone: _____

Crawl: _____ Walk: _____

How well does your clid tolerate tummy time? For how long? _____

_____

Does your child sleep:

❍ front ❍ side ❍ back

If their mattress elevated? ❍ Yes ❍ No

Do you cosider the child's sleeping pattern normal? ❍ Yes ❍ No

If no, please explain: _____

_____

Any falls from couches, beds, change tables, down stairs, etc? ❍ Yes ❍ No

If yes, please explain: _____

_____

Any traumas resulting in bruises cuts, stitches or fractures? ❍ Yes ❍ No

If yes, please explain: _____

_____

Any hospitalizations or surgeries? ❍ Yes ❍ No

If yes, please explain: _____

_____

Is the child breast-fed? ❍ Yes ❍ No

If no, what formula are they eating? What age was it introduced? _____

_____

_____

Any difficulties nursing? ❍ Yes ❍ No

If yes, please explain: _____

_____

Does the child favor one breast over the other? ❍ Yes ❍ No If yes, please explain: _____

_____

Is the child : Tongue tied? ❍ Yes ❍ No Lip lied: ❍ Yes ❍ No

Introduction of cow's milk at what age: _____ Began solid food at what age: _____

Typespes of solid foods: _____

_____

Food / Juice intolerance ❍ Yes ❍ No Type: _____

Is the child on or have taken any medication? ❍ Yes ❍ No

If yes, what are they taking? For how long? What are the dosages? _____

_____

Any ultrasounds? ❍ Yes ❍ No How many: _____

Reasons for being done: _____

_____

Any invasive procedures during pregnancy (IE amniocentesis, chronic villi sampling, etc.? ❍ Yes ❍ No

If yes, please explain: _____

_____

Any hyperactivity or restlessness? ❍ Yes ❍ No If yes, please explain: _____

_____

Prolonged temper tantrums or separation anxiety? ❍ Yes ❍ No If yes, please explain: _____

_____

Is the child in day care? ❍ Yes ❍ No Age of child when began daycare: _____

**Authorizing Consent for examination of a Minor (under 16 years):** Please Read Carefully!

In order for the health professional as indicated below to make a determination on the suitability of my child's guardian's case for care, I acknowledge and understand that a thorough evaluation must be completed. I have had the opportunity to discuss with the attending Doctor of Chiropractic about the nature and purpose of the examination process. I understand that there may be remotely associated risks with examinations, as there are with any and all healthcare treatments. In healthcare, the matter of whether any treatment is appropriate or not is determined by looking at the level of risk and comparing this with the level of expected benefit. I understand that I may ask the doctor to stop the examination at any time. I also understand that by signing this form, the chiropractor continues to be obligated for best practices delivered in the child's interests.

Patients Name: _____ Parent or Guardians name: _____

Date: _____ Signature( of guardian or parent): _____

Signature of Attending Chiropractor: _____

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